MEMORIAL
Belleville, Illinois 62226

Preoperative
Past Medical History

Patient Name:	Date of Birth: Best Phone #
Primary Care Provider: Phone #	Cardiologist/Specialist Dr: Phone #
Planned Surgery:	Surgeon: Phone #
Reason for Surgery:	Height: Weight:

	Yes	No		Yes	No
Do you have or are you being treated for high blood pressure? How many years?	☐	☐	Have you ever had a heart valve replacement or repair?	☐	☐
Do you have chest pain with walking/normal activity? With excercise? Y N	☐	☐	Do you have a pacemaker or defibrillator?	☐	☐
Have you ever had a coronary bypass or angioplasty?	☐	☐	Have you ever been told that you have a widening of your aorta or that you have an aortic aneurysm?	☐	☐
Have you ever had a heart attack? How many? ________ When? ____________________	☐	☐	Have you ever been told you have peripheral vascular disease?	☐	☐
Do you have a heart stent? How many? ________ When? ____________________	☐	☐	Have you ever had a stress test? Where? ________________ When? ________________	☐	☐
Do you have a weak or failing heart (congestive heart failure (CHF))?	☐	☐	Have you ever had a heart echo test? Where? ____________ When? ________________	☐	☐
Do you have an irregular heartbeat or heart rhythm?	☐	☐	Have you ever had a heart catheterization? Where? ______________ When? ____________	☐	☐
Do you have a heart murmur or mitral valve prolapse?	☐	☐			
Do you have or have you ever had a history of asthma?	☐	☐	Do you have difficullty breathing or wheezing?	☐	☐
Do you have history of chronic bronchitis or emphysema (COPD)?	☐	☐	Do you use oxygen?	☐	☐
Do you smoke? Packs/day____ How many years have you been a smoker? ______	☐	☐	Do you have a history of sleep apnea? CPAP? ________	☐	☐
Have you had any recent colds, fever or flu?	☐	☐	Have you ever been witnessed to stop breathing while asleep?	☐	☐
Do you have diabetes? Years: ________ Complications ________________________________	☐	☐	Do you take insulin?	☐	☐
Do you have kidney problems (other than stones)?	☐	☐	Have you ever had Hepatitis A/B/C/D? *(Circle)*	☐	☐
Do you have liver problems?	☐	☐			
Do you drink alcohol every day? *Drinks per day?* ____________	☐	☐	Do you use recreational drugs? *Specify:* ______________________________	☐	☐
Do you have a history of anemia?	☐	☐	Do you have a history of sickle cell trait?	☐	☐
			Do you have a history od sickle cell disease?	☐	☐
Do you take any blood thinners (e.g. Coumadin)?	☐	☐	Do you have a history of cancer?	☐	☐
Do you take Aspirin or Ibuprofen regularly?	☐	☐	Are you on Chemo Therapy?	☐	☐
Do you have seizures or take anti–seizure medications?	☐	☐	Do you have neuromuscular disease (Parkinson's ALS, etc?)	☐	☐
Have you ever had a stroke (CVA), mini stroke (TIA) or brain attack? When ________________________	☐	☐			
Have you been told that it is difficult to place a breathing tube in your airway (intubate)?	☐	☐	Do you have a history of severe reaction to anesthesia?	☐	☐
Do you or a family member have a history of high fever after anesthesia (malignant hyperthermia)?	☐	☐	Do you suffer from chronic pain?	☐	☐
Do you have a history of severe nausea and vomiting after anesthesia?	☐	☐	Any possibility you couold be pregnant? *Last Menstraual Period:* ______________________	☐	☐

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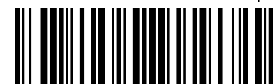

PATQUES

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